



## PATIENT REGISTRATION FORM

### PERSONAL INFORMATION

Last Name:	First Name:	MI:	Date of Birth: / /	Preferred Name:	Mother's Maiden Name:
Home Address:		Apt #	City:	State:	Zip Code
Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell ( ) -		Alternate Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work ( ) -			Social Security #:
Marital Status (Check one): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Life partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown		Name of Spouse: What is your current work situation: <input type="checkbox"/> Unemployed <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> Choose not to disclose or decline to answer		Email Address: Are you currently enrolled in school? <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> Not Enrolled <input type="checkbox"/> Choose not to disclose or decline to answer	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____				Do you need a translator? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### DEMOGRAPHIC INFORMATION

Race: <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown/Refuse to report	
Are you of Hispanic origin? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Hispanic, please check ethnicity origin: <input type="checkbox"/> Mexican, Mexican American, Chicano(a) <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic, Latino(a) or Spanish Origin <input type="checkbox"/> Cuban <input type="checkbox"/> Unknown/Refuse to report
Are you Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	If homeless, please specify: <input type="checkbox"/> Transitional Living Facility <input type="checkbox"/> Street <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Doubling Up
Do you reside in a Public Housing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an Advanced Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a Veteran of the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### SEXUAL ORIENTATION AND GENDER IDENTITY

What sex were you assigned on your original birth certificate? (Check one): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose	What are your preferred pronouns? <input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them <input type="checkbox"/> Other: _____
Do you think of yourself as? (Check one): <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Gay, lesbian, or homosexual <input type="checkbox"/> Bisexual or pansexual <input type="checkbox"/> Asexual or something else <input type="checkbox"/> Questioning or don't know <input type="checkbox"/> Choose not to disclose or decline to answer	To better serve you, what is your current gender identity? (Check one): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Trans Man/ Female-to-Male (FTM) <input type="checkbox"/> Transgender Female/Trans Woman/ Male-to-Female (MTF) <input type="checkbox"/> Additional Gender Category/ (or Other), please specify: _____ <input type="checkbox"/> Choose not to disclose or decline to answer

### EMERGENCY CONTACT INFORMATION

Name of Contact:	Phone Number of Contact:	Relationship to Patient:
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### HOW DID YOU HEAR ABOUT US?

<input type="checkbox"/> Flyer <input type="checkbox"/> Relative/Friend <input type="checkbox"/> Church <input type="checkbox"/> School <input type="checkbox"/> Event/Fair <input type="checkbox"/> Walk-In <input type="checkbox"/> Hospital <input type="checkbox"/> Internet <input type="checkbox"/> 2-1-1 <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> TV <input type="checkbox"/> Magazine <input type="checkbox"/> Eligibility Worker <input type="checkbox"/> Other _____	Social Media: <input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> Instagram <input type="checkbox"/> Email <input type="checkbox"/> Other: _____
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### PREFERRED PHARMACY INFORMATION?

Name of Preferred Pharmacy:	Preferred Pharmacy Intersections:	Preferred Pharmacy Phone Number:
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**I certify that the above information is correct to the best of my knowledge:**

\_\_\_\_\_  
Patient / Parent/ Guardian Signature

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

Registration Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_